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REVITALIZING PRIMARY HEALTH CARE/MATERNAL AND CHILD HEALTH: THE BAMAKO INITIATIVE

Progress report

SUMMARY

The present report is prepared annually as requested by the 1988 Executive Board. It describes the progress made with preparatory activities and individual country programmes for implementing the Bamako Initiative. The report continues the analysis of constraints and operational issues that have arisen during the implementation period. It describes the activities that UNICEF and the World Health Organization have undertaken, at the country level, in assisting Governments to revitalize primary health care, paying special attention to the poorest and most vulnerable groups, especially women and children.

During 1989, the Initiative has made considerable progress in gaining acceptance for its ideas, in developing programmes of action in 24 African countries and in demonstrating further progress in those countries which are already implementing programmes, namely, Benin, Guinea, Nigeria and Sierra Leone.

There is now an urgent need to secure donor support for specific activities, totalling over $32 million in supplementary-funded projects previously approved by the Executive Board. This African Initiative has now been adopted by many communities, and the financial support being provided is an indication that they are convinced of its importance. A similar financial commitment from the international community is now critical.

CONTENTS

	Paragraphs	Page
INTRODUCTION	1 - 10	3
I. BACKGROUND	11 - 13	5
II. PROGRAMME ACTIONS AND ISSUES	14 - 54	6
A. Mobilization and advocacy	14 - 20	6
B. Strengthening the provision of health services	21 - 33	7
C. Improving health financing	34 - 46	12
D. Improving the management of drugs and supplies	47 - 54	16
III. MANAGEMENT ISSUES	55 - 62	18
A. Collaboration with the World Health Organization	55 - 58	18
B. Co-ordination with other agencies	59 - 60	19
C. Technical meetings	61	20
D. Strengthening UNICEF capacity	62	20
IV. COUNTRY EXPERIENCE	63 - 107	20
A. Countries implementing the Initiative	64 - 79	20
B. Countries in the planning stage	80 - 102	24
C. Other countries in sub-Saharan Africa	103 - 106	29
D. Countries outside sub-Saharan Africa	107	29
V. RESOURCES	108 - 113	30

List of figures

1. Utilization of health centres - Benin 11
2. Health centres in Benin: expenditures/community revenues 15
3. Health centres in Guinea: expenditures/community revenues 15
4. Cost of chloroquine: selected countries 17
5. Drug costs - Mauritania 17

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INTRODUCTION

1. During 1989, continued advocacy and action in individual countries have enhanced the development of the Bamako Initiative, which was endorsed by the African Ministers of Health in 1987 and by the Organization of African Unity (OAU) in 1988. The policy framework of the Initiative has now been well established with the agreement of the Ministers of Health to joint World Health Organization (WHO)/UNICEF policy guidelines, which form the basis for assessing the readiness of countries to undertake broad-based activities for strengthening primary health care (PHC). The basic aim of the Initiative is to reinforce PHC at the district level, including the rehabilitation of health care services at the periphery. This approach is intended to enable peripheral health services to cover large segments of the population groups currently not being reached by the existing PHC system.

2. Community financing is the key to empowering people to be involved in managing their health care services. By ensuring an essential drug supply and appropriate training, health workers are able to provide the improved care sought by the population.

3. The clear linkage between the Initiative and the basic services approach has been acknowledged. Like basic services, community involvement and area-based or district-level approaches are important aspects of the Initiative. The progress achieved in universal child immunization (UCI) has also strengthened health care structures and logistics systems, and the Bamako Initiative is building on these foundations.

4. The specific strategies developed in individual country plans usually consist of three phases: assessment of PHC; preparation for implementation; and implementation of PHC services, often beginning in a few selected districts. To date, six countries have reached the implementation stage and 18 countries have initiated preparatory activities with WHO and UNICEF support. Particular aspects of interest include operational research activities pioneered by Benin, Guinea and Mauritania; detailed district-level situation analyses, such as that carried out in Sierra Leone; and well-directed studies, such as those on health sector financing in Uganda. In addition to the close collaboration with WHO, working relationships have been established with the World Bank and several non-governmental organizations (NGOs) active in PHC in Africa. International technical meetings, sponsored totally or jointly by UNICEF, have greatly enhanced this co-ordination.

5. The difficulties in implementing the Initiative cannot be underestimated, especially as they affect the eventual aim of going to scale in an adverse economic environment where communities are nevertheless expected to provide the financial base for extending and rehabilitating services. While communities are often willing to pay for health services, and in fact do incur significant expenditures for care and drugs obtained from both traditional and modern sources, their actual ability to pay is not fully known and this represents an area for further operational research. Some studies have been initiated but no specific results are available, although provisional data from Benin and Guinea suggest that restructured services can be cheaper and can provide better-quality care than the health services in existence before the implementation of the Initiative.

6. The Initiative's link to UNICEF work on structural adjustment is based on the need to examine all aspects of health sector financing and on advocacy for greater investment in health. The introduction of specific measures to ensure that the poorest and unreached are able to benefit from PHC is one of the central principles of the Initiative. It is the position of UNICEF that each country should establish practical and locally suitable working mechanisms for ensuring equity of access to care, irrespective of the ability to pay. The larger issue remains, however, that 50 per cent of African people have no access to PHC services, and the extension of such services would require considerable resources.

7. Given the extreme communications difficulties in many parts of Africa, logistics and management are very difficult aspects of the delivery of health services, and they remain a great challenge for the Initiative. The added factor of community participation in financing and managing local resources further compounds those problems, but the infrastructure that has been developed in accelerating UCI is proving to be a sound basis for the management of broader-based PHC activities, as confirmed in Benin and Guinea.

8. Community financing linked to a supply of essential drugs has given rise to an international debate on whether this will result in the increased misuse of drugs. Although the risk is real, it must be weighed against the proliferation of useless and expired drugs that are distributed throughout Africa. This situation has created considerable alarm and highlights the need for urgent action in developing and implementing national drug policies. In many countries this process has already been initiated by WHO. UNICEF and other agencies have stimulated reviews of prescribing practices and are supporting national efforts to train health providers in the correct use of drugs.

9. In emphasizing a broad-based approach to PHC, clear strategies for incorporating vertical programmes are necessary in each country. The experiences of Benin, Guinea and other countries in consolidating UCI through the revitalization of health care structures at the periphery provide models for replication elsewhere. As UCI goals are achieved, UNICEF will focus on the sustainability of UCI, which will depend in turn on the strengthening and extension of PHC networks.

10. The desired alliance between the community, the Government and international donors still needs to be developed, with the donors continuing to be observers to the initiatives of communities and Governments in many parts of Africa. Donor support is urgently needed if most countries are to initiate or sustain the steps they have taken to revitalize PHC services. The two major meetings in 1989 with donor Governments, interested NGOs, academic institutions and African health authorities have, it is to be hoped, assured all interested parties that this is an important initiative that responds to felt needs in a realistic and creative manner.

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I. BACKGROUND

11. The resolution on the Bamako Initiative, adopted by the African Ministers of Health at the meeting of the Regional Committee of the WHO/Regional Office for Africa (AFRO) in September 1987, was based on four already-adopted policies: health for all by the year 2000; the district-level strengthening of health systems; health as a basis for development; and 1988 as the Year of Protection, Survival and Development of African Children. The resolution called for the international community to collaborate with and support the development of the Initiative, including efforts to mobilize resources. In 1988, the UNICEF Executive Board subsequently endorsed the Bamako Initiative (resolution 1988/3, E/ICEF/1988/13) but emphasized the need to proceed carefully and in a planned manner.

12. The substantive portion of the Initiative was elaborated in the implementation guidelines that were approved by the WHO/AFRO Regional Committee in September 1988. The goal of the Bamako Initiative is to make PHC/maternal and child health (MCH) services universally accessible. This demands a number of developments, as included in the following eight basic principles:

(a) National commitment to accelerating the provision of universally accessible PHC services;

(b) Substantial decentralization to the district level of the Health Ministry's decision-making for the management of PHC;

(c) Decentralized management of community resources, thereby allowing the funds collected at local facilities to remain under community control;

(d) The application of consistent principles governing community financing for health care services throughout the different levels of the health system, making it inappropriate to provide free service at urban hospitals while requiring payment for community-based services;

(e) Substantial government financial support for PHC, to ensure that the health budget is maintained at least at its current level of support to district and local services;

(f) Policies on essential drugs that are compatible with, and complementary to, the rational development of PHC;

(g) Measures for ensuring that the poorest people have access to PHC services;

(h) The clear definition of intermediate health system and management objectives and the establishment of indicators to measure them.

13. These principles serve as the framework for a broad-based, decentralized strategy for strengthening PHC in a manner that is equitable and involves the community in managing and financing health services. The principles also provide a technical basis for determining how UNICEF and WHO support to countries can be most

effective. Over the past two years, UNICEF and WHO have given priority to reviewing the experience of several countries to ascertain their readiness to implement the Initiative and to support preparatory activities.

II. PROGRAMME ACTIONS AND ISSUES

A. Mobilization and advocacy

Mobilizing political leadership

14. UNICEF has continued to mobilize political leadership at the country level and to promote the principles of the Initiative at appropriate regional and international forums. At the WHO Regional Committee meeting in September 1989, held at Niamey, the African Ministers of Health re-emphasized the need to strengthen basic health services and to consolidate and expand work on the Initiative. In November 1989, African parliamentarians and journalists, meeting in Rome, expressed their appreciation for Italian support for African health care and urged the Government of Italy to continue to support the development of health programmes in Africa. In March 1990, political leaders, artists and intellectuals meeting at Bamako also endorsed the Initiative.

Other organizations

15. UNICEF has continued to function in liaison with the Pharmaceutical Advisory Group of the World Council of Churches/Christian Medical Commission and has participated in their ongoing deliberations on health care in Africa. In October 1989, UNICEF participated in a seminar held in Paris on the role of essential drugs in developing countries, organized by the Government of France and attended by representatives of the major French pharmaceutical industries and several NGOs. In November 1989, UNICEF was represented at a meeting at Geneva organized by a French study centre for senior government officials. Discussions focused on the relationship of the Bamako Initiative to the interests of the pharmaceutical industries and the need for the Government of France to support the Initiative in the context of its aid policy for Africa.

National-level advocacy

16. In individual countries, work has focused on increasing awareness of the need to revitalize PHC, based on national adaptations of the guiding principles. National PHC committees have been the principal partners in these promotional activities. These multisectoral groups are also the organizational base for technical decision-making. UNICEF and WHO have been active participants in the process, providing technical assistance as needed. An alliance of national and international partners is forming in some countries. This has led to collective situation analyses of PHC, support for preparatory activities and implementation, when appropriate. In Mali, for example, several workshops were held during 1989 to review the principles of the Initiative and to incorporate the views of different population groups. These consensus-building exercises have been among the most positive aspects of preparatory work in many countries.

17. District-level task forces in several countries have now emerged from national-level groups and they are organizing activities to develop the Bamako Initiative at the intermediate level.

Community mobilization

18. In the resolution creating the Bamako Initiative, community mobilization was recognized as a fundamental requirement for strengthening PHC, and the need to build on the success of the expanded programme on immunization (EPI) was stressed. The nature and degree of community involvement varies from country to country, depending on whether local communities have a history of participation in development efforts. One related aspect that has not been fully analysed, even in those countries where implementation is relatively well advanced, is the role of community education.

19. The need to train community leaders in management and finance has been recognized, but awareness-raising among community members has received less attention. The observation of women who bring their children to health clinics has shown that these women have little understanding of the services provided and see themselves as having no relationship to it. This may be partly due to the high illiteracy rates among women, but the fact that local committees are male-dominated and that health workers seem to place no importance on encouraging women's involvement may also account for women's apparent lack of interest.

20. Health workers have yet to understand that women's participation in the delivery of health services can actually contribute to improving the quality of such services. Community education is seen, therefore, as an important factor in the implementation of the Initiative, and linkages with the campaign to promote Facts for Life are planned.

B. Strengthening the provision of health services

21. A key issue has been the need to rehabilitate the network of peripheral MCH/PHC health centres and posts. It has been recognized that because of economic difficulties health systems were stagnating and could neither serve the needs of communities nor expand their coverage. For this reason, high priority is attached to strengthening the system through training and the rehabilitation of peripheral services.

National-level planning

22. The development of PHC under the Initiative emphasizes national capacity-building, starting with the formation of intersectoral national- and district-level task forces. These task forces assess the capacity of the health system to support PHC at district and community levels. In many countries, detailed studies are being undertaken on effective strategies for alternative approaches to decentralization, community financing, drug and medical supply logistics and the strengthening of management systems.

23. The status of PHC coverage varies from country to country, and individual elements of health services are often at different levels of development. There is sometimes great variance in levels of immunization coverage, the control of diarrhoeal diseases, the availability of pre-natal care, the management of acute respiratory infections, malaria treatment and control and the capacity to deal with the main causes of sickness in specific areas. The Initiative encompasses all those elements in a locally adapted, integrated approach to the provision of services.

24. In many countries, operational research is an increasingly important component of the Initiative. With the support of technical personnel from Benin, Mauritania has finalized a research protocol to examine the quality and coverage of health services and the willingness of consumers to pay. It is expected that this research will eventually form the basis of a regular monitoring system. In Ethiopia and Ghana, studies have been carried out on drug consumption and community responses to the use of drugs. In Benin, household surveys have been carried out in six areas covered by the national EPI/PHC programme to determine levels of health care expenditures for different socio-economic groups and reasons for the non-utilization of PHC services.

25. Initial contacts have already been established with the International Child Development Centre in Florence, Italy, to organize seminars on effective strategies for linking the capacity-building activities in support of child survival and development (CSD) in Africa to the Bamako Initiative. The mobilization of universities and respected academics to support operational research on the Initiative has potential for improving the technical quality of the work being carried out. These data will also provide new generations of medical and public health students with a wealth of information on PHC in many African countries.

Exchange of experience among countries

26. An important feature in the development of the Initiative is a clear strategy for increasing the exchange of knowledge and skills among African health experts. Collaborative efforts between Benin, Guinea and Nigeria to develop management training modules have been followed by many study visits to countries that have accumulated considerable experience in planning, management and community financing. Exchanges between East and West Africa have broadened the scope of these exchanges. It is worth noting that most countries already have a cadre of knowledgeable technicians possessing the capacity to plan and undertake preparatory activities.

District-level strengthening

27. As a result of inter-country collaboration, it is now understood that the success of the Initiative will depend on the gradual and systematic introduction of new activities, while increasing local-level capacity for operational planning, micro-planning and monitoring.

28. As part of the initial preparatory activities in most countries, thorough situation analyses have been conducted. The content of these analyses varies, although it has often been observed that there is a need to carry out a careful assessment of the pharmaceutical sector. Sierra Leone is conducting exhaustive district-by-district situation analyses in order to establish a comprehensive baseline for designing specific interventions. This process of careful analysis, detailed planning both at national and district levels, initial implementation on a small scale and district-level strengthening indicates that implementation is keeping pace with the capacities of individual countries and districts, as well as with the experience that has accumulated.

29. The data already available from some monitoring systems indicate that information systems are being given priority. In spite of the increasing patient loads and the extra time that is required for accurate record keeping, the need to collect information that is useful at the local level is being stressed. Strengthening services at the district level encompasses activities at district, subdistrict and community levels. This ensures that a supportive referral system exists at the district hospital level. In the majority of countries it is now recognized that referral institutions, particularly district hospitals, also need rehabilitation if they are to function as referral centres, provide supervision and serve as centres from which drugs and vaccines are distributed. The need for further collaboration among donor and development agencies is critical for creating the synergism to strengthen the various levels of the health system.

Quality of services

30. The introduction of fees without adequate planning and public education, reported in Ghana, Mozambique and Swaziland, where studies have been carried out, has led to some decrease in the utilization of government health services. Interestingly, those decreases have been accompanied by increased utilization of facilities run by NGOs which also charge fees. This suggests that the quality of services is a major determinant of utilization and that poor people are willing to pay for health care if it is perceived as quality care. The availability of essential drugs is not the only determining factor. The attitude of the attending health workers and the location of the facility are equally important. Quality in public sector health services is perhaps the most critical aspect to be addressed.

31. This has particular implications for government services. It implies the provision of continuous training and appropriate technical and managerial support for front-line health workers. The decentralization of budgets and financial management is critical in improving the situation of rural health workers. In both Benin and Guinea, health workers receive small bonuses from community-generated funds based on the approval of community committees.

32. When the planned introduction of fees is preceded by efforts to improve the quality of services, the downward trend in the utilization of services is reversed. The monitoring system in Benin has been collecting data on service utilization before and after the introduction of charges in February 1988. An examination of the average number of monthly visits per centre, based on data from

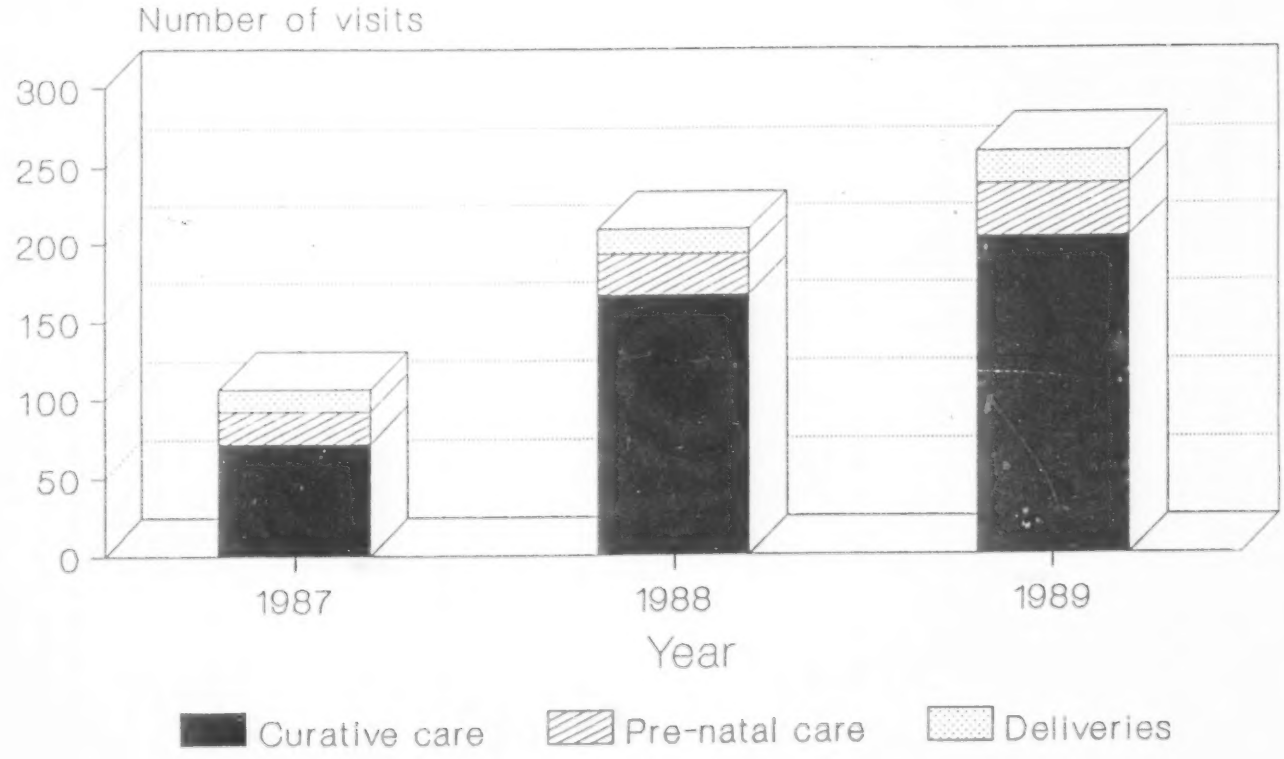
44 health centres between 1987 and 1989 (see figure 1 below), shows that overall utilization in 1988 doubled and increased a further 25 per cent in 1989. Not only have curative visits increased, but so have pre-natal visits and the number of deliveries. This trend indicates that by revitalizing the system, with an emphasis on curative PHC, there appears to be an increase in the use of services for preventive care. Further monitoring over time will lead to a more detailed assessment of the dynamics of service utilization, within the context of the Bamako Initiative.

Community-level services

33. Work so far has necessarily emphasized the rehabilitation of existing services, mainly at the subdistrict level, but the issue still to be addressed is how to extend services to the unreached. This equity issue is probably the most critical aspect of the Bamako Initiative since the resources to extend services, both in infrastructure and human resource terms, do not exist in most countries. Nevertheless, attention is being focused on existing community health workers (CHWs), particularly the traditional birth attendants (TBAs). In Guinea, outreach from the subdistrict health centre has been assured by TBAs who have been trained to include the treatment of common ailments and immunization in their work, with the idea that some of them will become CHWs. They handle five basic drugs for the most common complaints. Supervision from the centres is carried out on a weekly basis, but the supervisory capacity of the centres, which have only limited resources, is relatively low. Geographical extension of services will require major advocacy efforts to secure additional funds for investments and operating costs from national, local and other sources.

Figure 1

Utilization of health centres
Benin



Average monthly visits/centre,44 centres

C. Improving health financing

The economic climate and adjustment

34. Although Governments embraced the Alma Ata Declaration in the late 1970s and implemented health reforms, including the selection and training of CHWs, economic constraints have hampered the maintenance of vital supervisory and referral systems, and supplies have been either inadequate or simply unavailable. The quality of health centres and district hospitals has deteriorated at an alarming rate. Many community health personnel have worked under very difficult circumstances; they have become demoralized and many have abandoned their health responsibilities.

35. Despite some positive signs, the economic situation facing the majority of Africa's population has continued to decline and their purchasing power has been seriously reduced. The prospects that Governments will increase their budgetary allocations for essential operating costs are dim and, in most cases, Governments' real per capita spending on health services has stagnated.

National policy issues

36. The Bamako Initiative addresses many PHC policy issues. The overall allocation of resources to the health sector, and within the health sector for PHC, is under review. It is now widely recognized that there are more cost-effective ways to use resources by investing in lower-cost services, especially in rural areas. UNICEF is continuing to advocate that greater allocations should be made for the health sector and that within Ministries of Health increased priority should be given to PHC. UNICEF is also working with many Governments to identify points in the health system where productivity can be increased with existing resources.

37. The majority of African countries have now adopted some form of cost-sharing policy, which requires users of services to contribute to the cost of providing such services. Cost-sharing can take a number of forms: user charges for treatment based on the cost of the course of drugs (Benin, Guinea and Zaire); charges for services less directly tied to drug costs (Nigeria and Zaire); and insurance schemes that spread the cost over time and among community members (Burundi, Guinea-Bissau and Rwanda). Each system has its advantages and limitations, and the national planning process must make a realistic assessment of the strategy that is most suitable in each situation.

38. UNICEF is assisting Governments in examining their health financing systems. In Uganda, a national health financing task force has been convened with UNICEF support. The Government of Zambia, with support from UNICEF and the Church Medical Association, is reviewing its health financing with a view to expanding the mechanisms for collecting fees. In other countries, such as Ghana, Mali and Nigeria, studies are being conducted as preliminary steps towards changing national policy.

Equity and protecting the poorest

39. Equity has been a major concern of the Initiative since its inception. There is a specific need to ensure that the poorest people benefit from PHC. Countries have adopted a variety of approaches to protect the poor, depending on cultural norms and governmental tradition. Many countries, including Ethiopia, Nigeria and most francophone countries, have established a system for issuing certificates from local authorities to enable the poor to receive free treatment. It is recognized that, in many cases, the distribution of these certificates may not be based on need. Some countries, such as Benin, Guinea and Sierra Leone, rely on mutual help in the communities. This can be structured or be more ad hoc based on exemptions at the discretion of health care providers. In Ghana, church hospitals have created funds for the sick and poor which are used on the recommendation of the parish priest.

40. Mozambique, which is only at the initial study phase of the Initiative, has launched a social fund to provide subsidies for specific groups in urban areas. This step was necessary following a 30 per cent decline in health unit consultations in 1987, when fees were introduced without improvements in the quality of services. Subsequent studies have shown that one third of all prescriptions were not being utilized. The fund, managed by the Ministry of Health and financed by donations and contributions from the Ministry of Finance, provides the poorest people and certain other population groups with certificates that enable them to obtain health care services.

41. The Initiative has started by concentrating on strengthening the community level, but a number of countries are already planning to examine the consistency of cost-sharing at higher referral levels. Guinea is perhaps the country that is most advanced in this regard. The 1990 work plan includes the formulation of a policy for hospitals that will seek to strengthen the referral system at district and higher levels and establish financial mechanisms similar to those instituted for health centres. In Ghana, charges are the same at all church-assisted and public health institutions and the fees increase with the complexity of care.

42. It remains to be decided whether patients should be charged at each level of the system as they move up the referral ladder, or whether they should pay only at the initial point of contact, as is the case in Zimbabwe. While this system favours the patient, a one-time payment at the first referral level reduces the revenues for the higher-level facilities unless revenue sharing between levels is introduced for referral cases. This is not yet a significant problem because of the low proportion of cases referred, but it does point to the eventual need for more sophisticated financing systems once the revitalization process is more fully developed.

43. Although the measures to ensure equity vary considerably, there is increasing attention being given to this issue. It is the subject of specific operational research that started in Benin and Sierra Leone at the end of 1989, and some initial results are due in mid-1990. Increasingly, community-based action is viewed as the most effective way to protect the right of the poor to health services.

Financial management

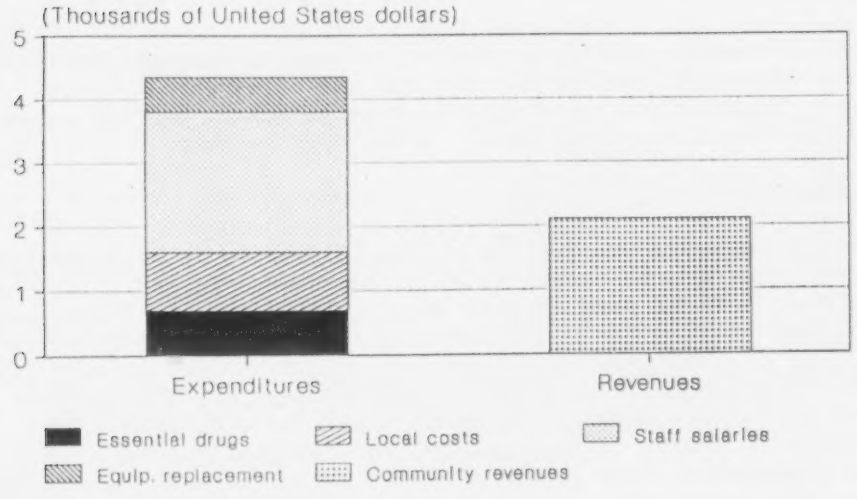
44. The management of funds, generated at the local level through fees charged to community members, remains an area of concern. Only a few countries have developed policies on the management of these resources, and in some places funds are accumulating or are being spent, based on budgets established by community committees. In some countries donors are still providing drugs, although in others, where implementation started one to two years ago, community funds are being used to replenish the drug supply. A number of countries have not yet embraced the principle that funds generated at the district level should be managed by community committees, but in many places local operating costs and bonuses for health workers are being supported by communities.

45. Two additional problems affect the replenishment of drug supplies. Foreign exchange is a basic requirement for purchasing drugs from overseas sources. In countries where external resources are still available for recently initiated programmes, this problem has not yet arisen, but in other places exchange controls are creating constraints. Among the short-term solutions are local currency conversion through United Nations agencies or other organizations that can use these funds. The viable longer-term solutions require Governments to authorize communities to convert their revenues into foreign exchange through convertible bank accounts or through government facilities. Inflation is a further constraint since it devalues funds held over long periods. These problems are being addressed on a country-by-country basis and efforts are being made to resolve these problems promptly to avoid excessive erosion in the value of local currency.

46. Monitoring systems in Benin and Guinea have provided data on the cost of services (based on the 44 centres in Benin and 33 in Guinea, with average populations per centre of 8,000 and 20,000, respectively). Indicative figures on overall costs and community revenues have been obtained for the first six months of 1989 (see figures 2 and 3 below). In 40 of the 44 centres in Benin, revenues have surpassed the levels needed for drug replenishment and local operating costs. With the immediate objective of community financing now achieved, additional investments have been made based on decisions by the communities. Guinea has reached an average of 90 per cent coverage of drug and local operating costs, and in 14 of 33 centres this level has been surpassed. It is now of interest to establish the magnitude of costs for revitalizing the health system. In Benin, assuming the overall average expenditure per centre to be the equivalent of around $9,000, the cost per inhabitant would be just over $1.00. Of this, about 50 cents is contributed by the community. In Guinea, the figure is somewhat lower, with an overall average expenditure per centre of approximately $12,000, for a per capita average cost of $0.60, of which the community contributes around 25 cents. The relative affordability of these costs, below 1 per cent of the gross national product per capita, give an early positive indication of the feasibility of long-term sustainability, assuming that utilization rates continue to rise and that people's socio-economic situations do not deteriorate substantially. These data also demonstrate that the fees required from patients to generate the revenues for operating costs decline with increased utilization.

Figure 2

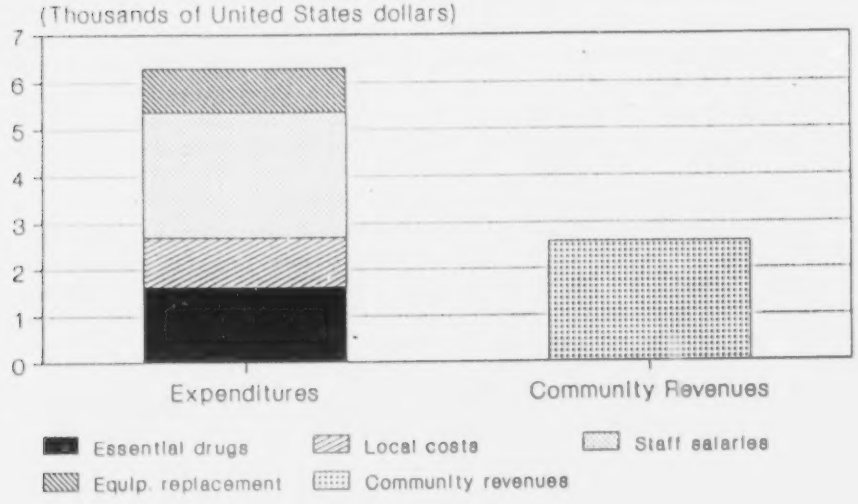
Health centres in Benin
Expenditures/community revenues



Average/centre,44 centres,6 months,1989

Figure 3

Health centres in Guinea
Expenditures/community revenues



Average/centre,33 centres,6 months,1989

D. Improving the management of drugs and supplies

National policies

47. WHO has played a leading role in the effort to develop national policies that are consistent with WHO guidelines on the rational use of essential drugs. The majority of African countries now have national drug policies, but the extent to which they are being effectively implemented varies considerably.

Storage and distribution

48. Drug storage and logistics are a focus of the Initiative in many countries. The management of central medical stores is being improved. In Ethiopia, Ghana and Nigeria, for example, the World Bank and WHO are providing important resources and technical support for upgrading the medical stores. At regional and district levels, there is a need to renovate and expand existing drug storage facilities. In Sierra Leone and Zaire, UNICEF is providing limited resources for improving storage facilities and for training and supervision in the management of pharmaceutical supplies. Buying in bulk through the UNICEF Procurement and Assembly Centre at Copenhagen, even taking into account relatively high in-country distribution costs, can often result in considerable savings for countries and for consumers (see figures 4 and 5 below).

49. Countries such as Benin and Sierra Leone are studying the relative advantages of procuring essential drugs in pre-packed kits as opposed to bulk procurement. Bulk supplies allow for greater responsiveness to local drug consumption patterns, while the kit system is convenient and reduces loss in transit.

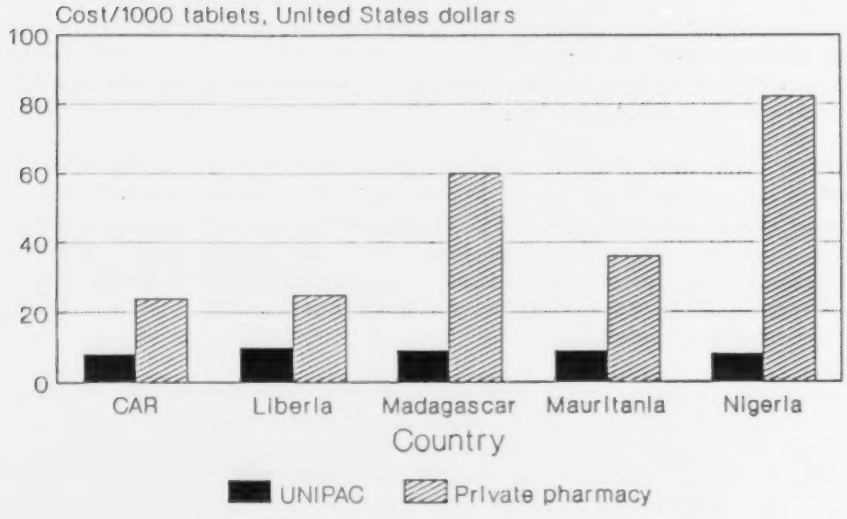
The rational use of drugs

50. The rational use of drugs continues to be a major area of concern, and the Initiative is seeking to ensure a steady supply of essential drugs. The tendency to prescribe several drugs at once is an undesirable practice, but one that is common in many countries. This practice makes improper use of the basic drugs that are intended for curative purposes and it wastes resources. The standard protocols for diagnosis and case management, as prepared by Benin, Guinea and Nigeria, have provided a more controlled prescribing system, especially at the community level. These protocols have been a significant step forward in rationalizing the use of drugs.

51. Training and supervision are also being strengthened to promote appropriate prescribing practices. The curricula for medical and other health personnel are being modified in several countries to improve the consistency and correctness of prescription practices. Frequent and careful supervision is necessary, however, to ensure that workers are following correct practices.

Figure 4

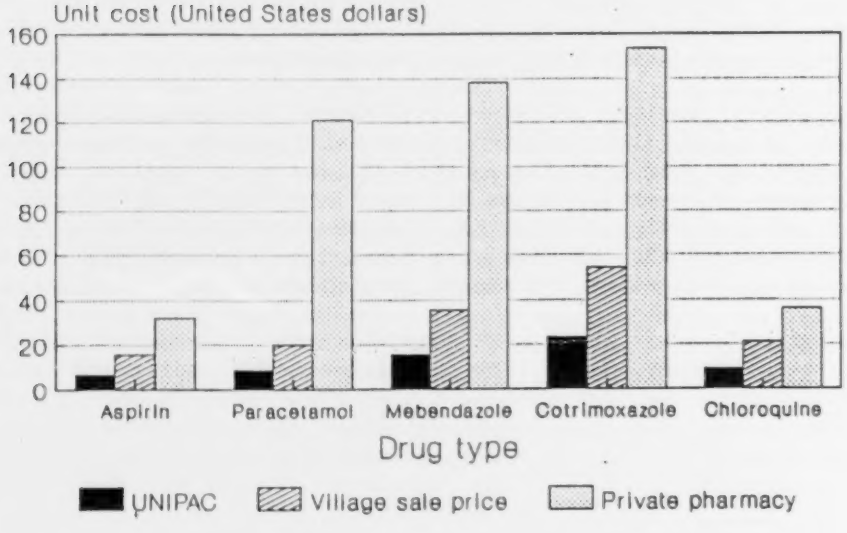
Cost of Chloroquine
Selected countries



Field office data

Figure 5

Drug costs - Mauritania
(Per 1000 tablets)



Field office data

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52. Another aspect of drug consumption patterns is the manner in which individuals and households use drugs. It is widely recognized that patients expect, and often demand, drugs that are inappropriate or useless. Individuals buy these drugs from private pharmacies or drug pedlars at high cost and they sometimes pressure health workers into providing them. Operational research on drug consumption patterns is under way in countries such as Ghana and Nigeria. The results of these studies will contribute to the design of educational activities for promoting a more rational use of drugs at all levels.

Local production

53. Local drug production has increased and many countries are reviewing their entire pharmaceutical sector. WHO, the African Development Bank (AfDB) and the World Bank are supporting these activities. In many cases, significant reforms are required, and increasingly, Governments are committed, with financial support from the banks, to undertaking these reforms.

54. In September 1989, WHO organized a meeting for the countries of the Eastern and Southern Africa Preferential Trade Area to discuss essential drug policies and the development of local pharmaceutical production. UNICEF has also initiated a systematic review of local production facilities, but this is under way only in those countries where implementation of the Initiative has already started.

III. MANAGEMENT ISSUES

A. Collaboration with the World Health Organization

55. Working relationships with WHO have been strengthened in the last year. The principal operational and policy linkage is with the WHO/AFRO in Brazzaville where a Bamako Initiative management unit has been established. Regular meetings on policy issues have been held between the two UNICEF Regional Directors in Africa and the WHO/AFRO Regional Director. In addition, there have been several meetings on strategies and programmes between the staff of WHO/AFRO, UNICEF regional offices and headquarters. Both organizations have also participated in the various technical meetings on the Initiative that have taken place.

56. Co-ordination with the WHO secretariat at Geneva has focused on specific technical issues. A task force has been created to identify and co-ordinate assistance to countries, particularly as this relates to operational research. The WHO action programme on essential drugs has been involved in the Initiative in a number of countries, including Burkina Faso, Guinea, Mali and Nigeria. Joint activities in the area of PHC cost analysis have also been undertaken and linkages are developing for collaborative efforts to strengthen district health services.

57. Both agencies agree that the Bamako Initiative is fundamentally a national effort that is co-ordinated, ideally, by an intersectoral task force and supported by UNICEF and WHO. There is also agreement that both agencies should provide guidance to countries on initiating implementation. A schedule of future consultations has been drawn up, including regular discussions on policy at the

head-of-agency and regional director levels, technical meetings between staff responsible for overseeing the Initiative in each agency, technical meetings at the country level, information exchange, joint missions and, where feasible, joint training and advocacy activities.

58. The organizational structures and working methods of WHO and UNICEF, particularly the distinction between the UNICEF country approach and the WHO regional orientation, have influenced collaboration and the speed with which each agency responds at the national level. These differences could be the cause of many difficulties, but they have been kept to a minimum. The WHO drug action programme has been active in several countries, reviewing national policies and priorities in countries such as Guinea, Mali and others where essential drugs programmes exist. Suggestions have been made for modifying and improving the joint guidelines on essential drugs based on experience to date, with special reference to operational issues and the pace of implementation.

B. Co-ordination with other agencies

59. UNICEF has maintained close contacts with the World Bank, which is investing considerable amounts in health care in Africa. In Nigeria, for example, the Bamako Initiative is focusing on action at the community level, starting initially in four of a total of 306 Local Government Areas (LGAs). UNICEF support for this programme complements the activities supported by the World Bank, the United States Agency for International Development (USAID) and other donors. The Bank will provide inputs for the programme on essential drugs and for strengthening the health system at national and State levels. Linkages with the World Bank have also been developed in other countries, including Madagascar, the United Republic of Tanzania and Zaire. Increasing contacts are developing with AfDB as it augments its support for restructuring the pharmaceutical sector and the local production of drugs in countries such as Angola and Guinea.

60. Meetings have been held with USAID at national and international levels, and contacts have also been made with other bilateral agencies. The German Agency for Technical Co-operation (GTZ) sponsored a workshop on the Bamako Initiative at Douala, Cameroon, in October 1989. This workshop focused on cost-sharing in Cameroon, community participation, supervision and rational treatment methods. The workshop was attended by UNICEF, WHO and NGOs. Staff from Canadian and Japanese development co-operation agencies have visited Ghana, Nigeria and Sierra Leone to assess the prevailing conditions and to examine possibilities for future co-operation. In February 1989, the French Foreign Ministry played a leading role in the community financing workshop held in Paris for francophone African countries. Staff from United Kingdom and Norwegian development co-operation agencies participated in the community financing workshop held at Freetown in September 1989. Continuous contacts have been maintained with the Italian Ministry of Foreign Affairs to follow up its extensive support for EPI and essential drugs programmes in Africa. These contacts are leading towards the planning of long-term support for Africa, based on a comprehensive approach to PHC in 29 countries.

C. Technical meetings

61. In addition to the technical meeting for francophone countries mentioned above, several other similar meetings have taken place. In September 1989, Health Action International, the Oxford Famine Relief Campaign and UNICEF held a workshop at Freetown to discuss community financing and other aspects of community participation in PHC raised by the Initiative. Health experts from several African countries, including the Ministers of Health of Nigeria and Sierra Leone, attended. Representatives from WHO/AFRO and from WHO headquarters also participated. The meeting allowed NGOs and others to gain a better understanding of the origins and nature of the Bamako Initiative. UNICEF and WHO, on the other hand, were briefed on the concerns of NGOs and donors.

D. Strengthening UNICEF capacity

62. UNICEF staff have also been trained, and a staff training package has been developed that contains modules on PHC, strengthening district-level health services, health sector financing, community financing, essential drugs and community participation. Representatives, programme officers and health project officers working in Africa have attended training workshops. The training package has also been distributed to other regions since several countries have expressed interest in initiating action along similar lines.

IV. COUNTRY EXPERIENCE

63. Countries in Africa can be grouped into three categories based on their implementation of the Initiative. The first group includes those that have already gone beyond demonstration projects to implementation in a number of districts, focusing on rehabilitating existing services, particularly at the subdistrict level. There are six countries in this group, all of which have had programme recommendations approved by the 1988 and 1989 Executive Boards. In the second group, the preparatory phase of analysis and planning is already well under way in several other countries, which have received, or are due to receive, an initial grant for these activities. A third group of countries is initiating situation analyses and establishing national committees to co-ordinate action.

A. Countries implementing the Initiative

64. Benin has accumulated considerable experience in strengthening PHC, including community financing, and is the focal point for information exchanges among countries. For more than five years, Benin has been developing the Pahou PHC project, as well as projects supported by co-operation with the Governments of Switzerland, the Federal Republic of Germany and the Netherlands. In 1988, the country added 44 subdistricts, and in 1989, a second phase of expansion brought it to the current level of 300 subdistricts in 70 districts, of a total of 517 subdistricts in 86 districts. Implementation currently shows a consolidated effort to expand programmes to the national level. Data from the 44 subdistricts cited

above indicate preliminary positive trends in service utilization and the generation of community funds. This is occurring despite severe economic constraints in the country.

65. WHO and the World Bank have continued to support policy development. Early in 1989, a new national health strategy was adopted that favoured decentralization through strengthened district-level facilities and allowed expenditures and revenues to be managed by people working in district and subdistrict facilities. The programme is working towards the integration of all PHC elements, including immunization, which had previously been operated as a vertical programme.

66. In Benin, community health committees at the subdistrict level are responsible for indigents in the community, and a research protocol has been designed to measure the results and effectiveness of this approach. Another study will examine the extent to which structural adjustment is influencing the population's ability to bear some of the PHC costs. The use of accumulated funds for operating expenses and the replenishment of drugs will be closely monitored. To ensure a continuous and appropriate supply of drugs, a central purchasing unit is being created to serve all partners that are active in the provision of health services. Some 10 to 15 essential drugs, procured locally, are being tested.

67. In Guinea, the Government's community-based PHC strategy integrates the various components of PHC, including immunization and essential drugs. A technical co-ordination committee, directed by the Ministry of Health and with representatives from the Ministry of Planning and the State Secretariat for Decentralization, oversees the work. Both UNICEF and WHO participate in the quarterly meetings of this co-ordination committee. The country's national policy on decentralization allows the district level to plan its development and manage local resources for health. This policy enables communities to retain control over the funds they generate. In the 97 centres currently in operation (there are around 300 such centres in the country), health centre management committees have established their own budgets.

68. Since the start-up of the programme, WHO has provided technical support for the essential drugs component and there have been frequent visits from experts in the WHO drug action programme. These activities have laid the groundwork for the infusion of resources that will come from AfDB to strengthen the role of the central pharmaceutical co-ordinating body. In 1990, a company representing a joint venture between the public sector and private enterprise will initiate the production of chloroquine and a few other drugs for local consumption. All NGOs active in health participate in the national programme. Common registers, drugs, prices and materials are used, and biannual co-ordination meetings are held to review implementation.

69. Monitoring systems have been consolidated and data from this source have been cited above. The revenues from price mark-ups of around 60 per cent are spent on operating costs and on small incentives for health workers. The accumulated funds are held in interest-earning bank accounts until they are needed to replenish the supply of essential drugs. In 1990, it is planned to extend the programme to

another 70 centres and to strengthen district hospitals. MCH services will also be extended to the village level through TBAs whose trainers/supervisors are currently being trained.

70. Based on 1988 data, in Kenya private and NGO contributions to the health sector amount to around 42 per cent of both recurrent and development expenditures. NGOs have always charged fees, and many NGO programmes are self-financing. The fee structure is based on services, drugs prescribed or a combination of both. UNICEF support for the strengthening of PHC is channelled principally through integrated rural CSD programmes in six of the country's 42 districts.

71. During 1989, the Kenyan Government, particularly the Ministry of Health, began introducing cost sharing at all levels of the public health system. This policy shift was encouraged by both the World Bank and USAID as a means of financing non-staff recurrent costs during the current period of economic austerity. UNICEF has been particularly concerned about the continuity of the essential drugs programme during 1990 and beyond when the major donors, the Danish International Development Agency (DANIDA) and the Swedish International Development Authority (SIDA), will reduce their levels of funding for recurrent costs.

72. The Government has introduced charges for out-patient services throughout the referral chain. A major innovation will be the creation of facilities at the district level for receiving and disbursing the funds generated by user charges. UNICEF has supported a study in Meru District on the willingness and ability of community members to pay for health care. The study found that people in the district were prepared to pay for what they considered to be improved curative services. The study also helped to provide the basis for establishing affordable fees. A waiver system, enabling people who are unable to pay to have access to health care, is under discussion.

73. Nigeria has been one of the most active participants in the Bamako Initiative, and the Government views it as a strategic opportunity for strengthening community-based health care. Activities have been initiated in four of 306 LGAs. Within the three-tier system of Government (federal, state and local), there is a deliberate policy to decentralize functions and responsibilities to LGAs. The Government has increased federal subventions to these local structures and they now have greater authority to plan, allocate resources and involve the community.

74. Community financing, as well as the legal framework for user charges, pricing and fee exemptions, are being developed. Currently, LGAs control the revenue from user charges, and recently the participating communities have been given concessions to establish autonomous accounts outside the government system. These accounts are used to replenish the supply of essential drugs. Village health committees are expected to set prices for essential drugs, allowing for replenishment, transportation, administrative costs, inflation and fee exemptions. Staff at all levels have been trained and studies have been initiated on management capacity at the community level, the pharmaceutical sector, the prospects and problems of the rural banking sector and on quality control of essential drugs.

75. Sierra Leone hosted an NGO/UNICEF-sponsored study/conference in September 1989, and benefited from the detailed assessment of those who visited the field. The programme proposal for the implementation of MCH/PHC, based on the principles of the Bamako Initiative, has been accepted as the national plan for 1989-1993, including EPI/UCI activities. This is directed by an MCH co-ordinating committee of the Ministry of Health. The Bamako Initiative has been incorporated during the last year as the health strategy within the UNICEF country programming process, which is the goal for all countries interested in the Initiative. The new country programme recommendation for Sierra Leone is being presented to the 1990 Executive Board (see E/ICEF/1990/P/L.10).

76. During 1989, the implementation of the Bamako Initiative began in two of 12 districts in the Western Area, including Freetown, the capital. The population in those three areas accounts for 31 per cent of the total population, but access to health services is around 10 to 15 per cent. PHC is financed locally through treatment fees and drug sales. The decentralization of activities and funding has been accepted and, to some degree, already implemented. District health teams have been strengthened to enable them to handle the added responsibilities. Some district bank accounts have already been opened, and during 1990 such accounts will be opened in all 12 districts.

77. A comprehensive situation analysis for each district is prepared before implementation of the Initiative begins. These analyses provide the baseline against which progress can be measured. Operational research activities were initiated in late 1989 to assess the equity aspects of community financing, to evaluate the role of the traditional care providers and to measure the impact of increased community financing on the utilization of health services. Community participation is still only in the initial stages and 18 chiefdom (subdistrict) health development groups have been created, each of which will in turn establish and support similar village groups. In Sierra Leone, as in other countries, there is a tendency to prescribe multiple drugs, many of which are of little therapeutic value. A Pharmacies and Drugs Act has been passed by the Government and a draft national drug formulary has been prepared. These measures and appropriate training should help to rationalize treatment schedules.

78. The Government of Togo has spent the last year in intensive preparation for implementing the Bamako Initiative. Activities are being co-ordinated by the National Health Director and a national team supported by UNICEF and WHO. A policy document on measures to strengthen MCH/PHC is being prepared, outlining the commitment to essential drugs, management and community financing. Considerable emphasis has been placed on training, including a national workshop on the reinforcement of integrated MCH/PHC activities and five regional training sessions for 21 district medical officers and their respective management teams. A better understanding of user fees and community financing mechanisms now exists.

79. Several major studies have been undertaken to assess the availability of and access to health care, the various existing mechanisms of community management and the supply and distribution of essential drugs. Togo has taken a comprehensive approach to preparing the Initiative, and more than a year has been spent on

developing the conceptual framework, examining special problem areas and promoting national and local awareness. The actual implementation of activities began in early 1990.

B. Countries in the planning stage

80. The present section reports on activities in countries receiving, or due to receive, support from the UNICEF Bamako Initiative global reserve fund and those presenting related recommendations to the 1990 Executive Board.

81. In Burkina Faso, an interim evaluation of the existing essential drugs programme will be followed by an assessment of management capacity, with special emphasis on the supply and distribution of essential drugs. These issues are examined in conjunction with other areas of concern, such as inadequate policies on essential drugs, decentralization and community involvement. During 1990, studies will be carried out on drug consumption patterns and supply logistics, the financing of PHC in each province, the situation of PHC development and the epidemiological characteristics of different regions.

82. Preparatory activities in Burundi are well advanced for the rapid expansion of PHC over the next three years. An interesting and innovative approach allows families to pay for health cards in advance. This new arrangement is now available to 15 per cent of the population. The management of the programme was decentralized in early 1989, and it is estimated that $4.70 per family per year will cover the costs of essential drugs. This figure falls within the original global estimates of between $0.50 and $1.00 per person per year. Health care will remain free for children under five years of age, thus creating an incentive for families to follow correct child health practices. In August 1989, Burundi elaborated a detailed proposal for preparatory activities, including preliminary studies that would assess the real potential for community financing.

83. In Cameroon, the Government is committed to revitalizing PHC, taking advantage of the relatively developed health infrastructure with health committees at each level, including villages. Programmes supported by GTZ, USAID, the Government of Belgium and NGOs have provided experience in cost-recovery schemes.

84. The recent GTZ-sponsored workshop held at Douala, Cameroon, allowed for an in-depth discussion of issues related to the Initiative, including the economic, social and cultural diversity of Cameroon, which stretches from the southern rain forest to the northern Sahel. Activities in 1990 will concentrate on PHC policy development, including the analysis of current community-based services and an evaluation of the various experiences in community financing. Future analyses will need to focus on the development of a national essential drugs policy and a policy for decentralized management. The preparatory phase of the Initiative will coincide with the elaboration of the new country programme recommendation to be presented to the 1991 Executive Board.

85. In spite of the difficult social and economic circumstances facing Ethiopia, the country is attempting to expand its community-based MCH/PHC services to all

awrajas (districts). The Government plans to assist awrajas in developing cost-sharing and community control mechanisms for health programmes. Community participation in health is enhanced by the health committees established at district and subdistrict levels, although no definite policy on decentralization exists. User fees are already being charged, and a more rational system of community financing and management is envisaged. Revenue generated by fees for health services and drug sales currently reverts to the national treasury. Free-care certificates to allow access to free services are provided for individuals whose incomes are less than the equivalent of $25 per month. With assistance from the Government of Italy, the country has developed the capacity to manufacture and distribute a range of essential drugs.

86. WHO and UNICEF have concentrated on advocacy and the provision of technical support, and both agencies participate in the meetings of the technical committee charged with elaborating a strategy for implementing the Initiative. Studies and training emphasizing MCH/PHC management, the rational use of drugs, drug supply management, cost recovery, financing and management systems will be the focus of preparatory activities. The initial plan is to train health and other workers and to integrate the essential drugs programme and other PHC elements in 20 awrajas.

87. Several steps have been taken to strengthen the district-level management of PHC in Ghana. Fees for treatment were introduced somewhat arbitrarily in 1987, and one study has shown that service utilization rates declined initially, mainly due to the lack of improvement in the services provided. Although attendance has risen again in urban areas, poor rural areas still lag behind. A comprehensive essential drugs policy is being formulated and the Government is planning to provide drug kits on a regular basis to 350 health centres in low-income areas. It is expected that this will help to improve the quality of services. The Bamako Initiative in Ghana is incorporated within the national programme to mitigate the social costs of structural adjustment, which is supported by the World Bank, the United Nations Development Programme (UNDP), the World Food Programme (WFP), the International Labour Organisation (ILO), UNICEF and others.

88. One aspect of this multi-agency effort is a UNICEF contribution of $2 million, approved by the 1989 Executive Board (E/ICEF/1989/P/L.26). These funds are being used to procure essential drugs for distribution at the district level and to train health workers at district and community levels. An operational research group has been formed to collect baseline data from five selected districts and to help in the elaboration of a national drug formulary. The programme in Ghana is still oriented towards the provision of essential drugs, but during 1990 this should give way to a broader analysis of the PHC situation and the development of strategies for revitalizing MCH/PHC.

89. In Mali, an ad hoc group under the Health Planning Director and including various staff from the Ministry of Health, with the participation of both UNICEF and WHO, worked during the year to develop an action plan for the Initiative. The first step has been to develop a national plan that includes the key components of decentralized health planning and management, the provision of essential drugs and community involvement in management and financing. Following a 1988 evaluation of the pharmaceutical sector, in May 1989 the Council of Ministers approved a contract

with the Central Pharmacy Company giving them the exclusive right to import and sell drugs, on the understanding that prices would be competitive and that 60 essential drugs would be continuously available. The Council of Ministers also approved the general objectives and strategies of the Bamako Initiative, and specific preparatory activities are scheduled to begin in early 1990. It is envisaged that action will continue in a carefully planned way, given the size and complexity of the country and the diversity of experience already gained in different regions.

90. Mauritania has made steady progress with preparatory activities during the past year. In March 1989, a national decentralization policy was initiated in the health sector, leading to the creation of regional health action departments with autonomous responsibility for managing human and material resources. The national co-ordinating committee for PHC and for implementing the Bamako Initiative, an intersectoral group with the participation of UNICEF and WHO, elaborated a guide for community PHC management committees, allowing for their autonomy in financial management. A portion of the funds generated will be sent to the central level to guarantee the supply of essential drugs. The strategy for preparing to implement the Bamako Initiative includes policy development, initiating and monitoring field activities in two demonstration areas covering a population of 70,000, maintaining ongoing PHC action and developing an operational research programme. The present revitalization builds on a decade of experience in community-based PHC, but it has been recognized that there is a need to examine critical issues such as the lack of an essential drugs policy and a national drug formulary. A monitoring system and a programme for operational research have been designed, including household surveys, to assess families' expenditure on health and the potential for community financing. The World Bank and AfDB are developing a plan for comprehensive support to the health sector in Mauritania, with emphasis on assuring an adequate drug supply, strengthening management structures within the Ministry of Health and supporting the infrastructure in four regions.

91. Rwanda is well advanced in policies for PHC, including the management of essential drugs, decentralization and financing. In fact, people have been paying for health care since 1974, and the funds collected by the health centres have been given to the local administration for general development costs. Hospital fees have gone into the national treasury. There is now intensive activity in Rwanda to reorient the essential drugs programme based on the principles of the Bamako Initiative. Exchanges with Benin, Kenya and the United Republic of Tanzania have allowed government staff to make useful observation visits. A guide for the reorientation of PHC has now been developed and its implications for change are currently being studied in the Ministry of Health. The main preparatory activity is to transform current policies and practices into a national plan for revitalizing PHC in the country.

92. The United Republic of Tanzania is another country that has benefited from a large essential drugs programme since 1983 with the support of DANIDA, UNICEF and WHO. Local taxes, which are managed at the district level, together with government revenues and donor assistance, have contributed to financing development action at the local level. The country also has a comprehensive PHC policy and recently, with WHO assistance, has drafted a national drug policy. So far, there

is no indication that the Government will introduce charges for public health services, although fees are charged by NGOs and in privately owned facilities. A study of the health services operated by NGOs is currently under way to examine financing, user fees and the communities' perception of NGO services. The study will contribute to the development of long-term alternatives for financing health care in the United Republic of Tanzania, including the possibilities for health insurance schemes.

93. The initial proposal of Zaire on the Bamako Initiative focuses on enhancing community management of PHC, based on the population's demonstrated willingness and capacity to pay for health care despite low per capita income levels. Since 1982, Zaire has had a national PHC policy that led to the establishment of 306 health zones. A meeting in July 1989 to assess the country's preparedness for the Initiative, with the participation of the Government, UNICEF, WHO, USAID and NGOs, pointed to the need to strengthen supply/distribution systems and to enhance the role of local health committees in the management and control of community financing, taking full account of NGO experience.

94. The level of decentralization and the organization of health zones are special strengths. The World Bank has earmarked a major loan for the social sectors as part of its overall adjustment package in Zaire. The loan will support the decentralization of health services and the provision of essential drugs. The most effective use of UNICEF inputs in essential drugs management at the national level and the involvement of UNICEF in zonal PHC activities are issues that are being reviewed through studies and discussions with national and regional counterparts. Essential drugs provided in 1989 have now been distributed to a number of regional depots and the planning process for developing the new country programme takes place during 1990. In developing the new programme, a careful effort is being made to group the various elements of UNICEF co-operation within a comprehensive strategy for strengthening PHC in Zaire.

95. Despite the ongoing war, the country programme recommendation of Mozambique to the 1990 Executive Board (E/ICEF/1990/P/L.6) is based on a change in health policy from an emergency orientation to increasing coverage and improving quality, efficiency and sustainability of the MCH/PHC system. The introduction of user charges in 1987 led to a decrease in health centre attendance, and on average only 4.5 per cent of drug costs were recovered in 1988. As a result, the Ministry of Health is preparing an area-based pilot programme, based on the principles of the Initiative, to test strategies for improving the PHC system, promoting community participation and ensuring the sustainability of integrated MCH/PHC services in the context of the essential drugs programme and adjustment with a human face.

96. The recommendation for Uganda (E/ICEF/1990/P/L.7) similarly accentuates this transition from basic survival strategies to development concerns. It emphasizes community participation and the provision of sustainable, efficient and cost-effective health services at the village level. The essential drugs and EPI programmes have succeeded in revitalizing the health services, and the new recommendation is a move towards integration and co-ordination with the other MCH/PHC components, combined with the strengthening of the district-level management capacity. The creation of a national task force on health financing

reflects the Government's concern for the sustainability of the underfinanced health system and its resulting poor quality. The studies to be undertaken on recurrent costs are likely to be followed by the introduction of cost sharing, linked to the essential drugs supply.

97. The country programme for Chad (E/ICEF/1990/P/L.9) proposes to develop an effective, efficient and sustainable PHC system, emphasizing the strengthening and extension of the PHC network and building on the logistical infrastructure created by UCI. Cost containment is to be achieved through improved management, community involvement and community financing to offset operating and essential drug expenses. Mechanisms for financing PHC are currently being field-tested in some area-based programmes.

98. Madagascar, where severe economic difficulties are affecting the health system, is already testing different approaches to community financing. These include both pre-payment schemes and user fees linked to the supply of essential drugs in pilot projects. At the national level, the decentralization of PHC management and community participation are the key government strategies for the health sector. The country recommendation (E/ICEF/1990/P/L.4) proposes support for the implementation of these strategies to revitalize PHC, beginning with studies on various cost-recovery experiences.

99. Cape Verde has managed to create an effective PHC/MCH system over the last decade. The major concern expressed in the country recommendation to the Board (E/ICEF/1990/P/L.8) is the fragile nature of the system, both economically and institutionally. Key strategies to address the problem focus on integrating vertical health programmes into the PHC structure and strengthening the institutional capacity to support PHC. Community participation in PHC management and cost recovery are also highlighted, with special emphasis on creating effective and credible mechanisms for financial management.

100. In Equatorial Guinea, three distinct phases for strengthening PHC have been identified. The first includes policy development and the organization and training of key staff. This is to be followed by testing in demonstration areas and then gradual expansion.

101. Revolving drug funds have been operational for some time in many parts of Liberia, and this experience will form the basis for implementing the Initiative. The revolving funds are being assessed and analysed in conjunction with studies on the functioning of the various levels of the referral system and studies on the overall situation of MCH/PHC in the country.

102. The Sudan has already presented a proposal for preparatory activities, particularly for policy development, and this has received support from the Bamako Initiative global reserve fund. A national task force has been working, with UNICEF and WHO support, to review current Sudanese experience, and operations are expected to start in the North Kordofan District.

C. Other countries in sub-Saharan Africa

103. In addition to the countries mentioned above, most other countries in sub-Saharan Africa are in the initial stages of reflection on the Bamako Initiative. Angola, for example, where rural health services have deteriorated considerably as a result of the prolonged war, will review essential drug supply and management as a first step. A comprehensive situation analysis of PHC has been carried out in the Central African Republic by the Pan-African Development Institute, with UNICEF support, and this has led to an initial review of policy implications for implementing the Initiative. Through an established intersectoral national committee for the Initiative, the Congo has produced the first outline of a plan of action for preparatory activities, starting with a review of existing experience, for example, in the Niari region where GTZ has been supporting a project.

104. Initial meetings have been held in Côte d'Ivoire between the Government, WHO and UNICEF to launch the planning process for the Initiative. The Gambia has for many years emphasized PHC as the national strategy for health development. Cost recovery was introduced into the health system in 1988 to improve the availability of funds for non-salary recurrent costs, and an evaluation of this financing system will be a first step towards implementation of the Bamako Initiative. In Guinea-Bissau, a Ministry of Health task force, including WHO, UNICEF and NGOs, is analysing the introduction of co-ordinated PHC teams at district and local levels, reviewing the experience of the essential drugs programme supported by the Government of Italy and assessing financing methods. The country has considerable experience in local pre-payment mechanisms (the abota system), which could be the basis for appropriate community financing schemes and PHC management.

105. Research and the formulation of a national strategy are the specific plans for initiating activities in Malawi. These plans will be presented to the national PHC committee. In the Niger, an initial assessment will be made of the policy and organizational implications of the Bamako Initiative.

106. In Senegal, the Ministry of Health, WHO and UNICEF have agreed to approach implementation of the Initiative in stages, starting with studies on the functioning of health services at the peripheral level and community organization, taking into account national experience. A joint UNICEF/WHO team visited Sao Tome and Principe in December 1989 to establish a framework for developing the Initiative in that island-country. Somalia has taken the first steps in planning, focusing particular attention on decentralized management and community financing mechanisms. In Swaziland, operational research on PHC/community financing will be undertaken in the context of the situation analysis update for a new country programme recommendation. A review of national health financing and specific financing mechanisms at the local level is being carried out through UNICEF in four countries in southern Africa: Botswana, Lesotho, Zambia and Zimbabwe.

D. Countries outside sub-Saharan Africa

107. The Bamako Initiative has attracted considerable interest outside of sub-Saharan Africa. Nepal and Viet Nam are two countries that have begun to review the situation of PHC in a comprehensive way. Community financing and a more systematic supply and management of essential drugs are the areas of prime concern. National workshops have been held in these countries. The experience of other countries in implementing the Initiative and the major issues that have arisen are serving as a framework for overall policy.

V. RESOURCES

108. Preparatory activities for the Bamako Initiative have been funded principally from the global reserve of $12.5 million from general resources, $2 million of which was approved by the 1988 Executive Board (see E/ICEF/1988/P/L.40) and the remaining $10.5 million by the 1989 Executive Board (see E/ICEF/1989/P/L.26). Of this, $5.4 million was specifically earmarked for seven countries and $3.0 million for other countries as and when they were ready for initial activities. The remaining $4.1 million was allocated for global support over three years, including operating costs of the Bamako Initiative Management Unit in New York, advocacy efforts at conferences, seminars and workshops, support to operational research activities and collaboration with WHO. By the end of 1989, the following amounts were transferred from the global reserve to specific country programmes for use beginning in 1989, after the receipt and assessment of proposals and budgets:

Country	Amount (In thousands of United States dollars)
Benin	400 000
Burundi	209 000
Cameroon	260 000
Ethiopia	330 000
Ghana	2 000 000
Kenya	200 000
Mauritania	400 000
Nigeria	600 000
Rwanda	150 000
Sierra Leone	600 000
Sudan	200 000
United Republic of Tanzania	40 000
Total	5 389 000

109. With regard to supplementary funding proposals, the following amounts are still unfunded:

Country	Implementation period	Amount (In thousands of United States dollars)	Document number E/ICEF/-
Benin	1989-1993	5 646	1989/P/L.4
Guinea	1988-1993	6 200	1988/P/L.32
Kenya	1989-1993	5 895	1989/P/L.2
Nigeria	1989-1991	3 235	1989/P/L.8
Sierra Leone	1989-1993	8 008	1989/P/L.22
Togo	1990-1994	3 007	1989/P/L.9
Total		31 991	

110. Should donor support fail to materialize in the near future, the potential loss of continuity and dynamism in these six countries will be a major cause for concern.

111. In addition, a number of countries are presenting supplementary funding proposals to the 1990 Executive Board for the continuation of UNICEF support to health sector activities. Since many of those countries have already embarked on preparatory activities for strengthening PHC along the lines of the Bamako Initiative, a more consolidated approach to programming will gradually be introduced, leading to an integration of basic health services with greater community involvement in management and financing.

112. Of note is the proposal of Angola for strengthening the essential drugs programme by assessing the potential of community financing as a means of revitalizing PHC services, including the incorporation of specific interventions. The long-term efforts of Ethiopia to revitalize PHC will be based on the preparatory activities currently under way. The United Republic of Tanzania also aims to strengthen and expand its essential drugs programme, and UNICEF will continue to advocate an assessment of the long-term sustainability of this effort and the potential role of alternative financing mechanisms.

113. In Burkina Faso, it is recommended that support to the essential drugs programme should continue during the transition to strategies for PHC strengthening in accordance with the Bamako Initiative. The same is true for Equatorial Guinea, given the country's commitment to reinforce PHC.